

Disaster Preparedness for Limited English Proficient Communities: Medical Interpreters as Cultural Brokers and Gatekeepers

SHARYNE SHIU-THORNTON, PhD^a

JOSEPH BALABIS, MPH^b

KIRSTEN SENTURIA, PhD^c

ARACELY TAMAYO, MSW, MPH^b

MARK OBERLE, MD, MPH^d

SYNOPSIS

Current disaster and emergency response planning does not adequately address the needs of limited English proficient (LEP) communities. The complexities of language and cultural differences pose serious barriers to first responders and emergency providers in reaching LEP communities. Medical interpreters are potential key cultural and linguistic linkages to LEP communities. This project established a collaborative partnership with the Interpreter Services department of Harborview Medical Center in Seattle, Washington. In summer 2004, a pilot assessment of the training background and work experiences of medical interpreters was conducted that focused on training needs for disaster/emergency situations. Overall, medical interpreters identified a need for disaster preparedness training and education. Medical interpreters further reported that LEP communities are not prepared for disasters and that there is a need for culturally appropriate information and education.

^aDepartment of Health Services, University of Washington, Seattle, WA

^bHuman Services Policy Center, University of Washington, Seattle, WA

^cDepartment of Public Health, Seattle-King County, Seattle, WA

^dSchool of Public Health and Community Medicine, Epidemiology and Health Services, University of Washington, Seattle, WA

Address correspondence to: Sharyne Shiu-Thornton, PhD, Department of Health Services, Box 357660, University of Washington, Seattle, WA 98195-7660; tel. 206-616-2940; fax 206-543-3964; e-mail <sharyne@u.washington.edu>.

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"I would like to know as much as possible about the disaster and how I can prepare for it, because if I know that, I can transfer the knowledge to my community."
(Medical interpreter, interview, August 2004)

Current disaster and emergency response planning does not adequately address the needs of limited English proficient (LEP) communities. Disaster scenarios challenge the multiple systems of care and emergency responses to effectively reach all citizens, including vulnerable, diverse populations. In particular, the complexities of language and culture pose serious barriers to first responders and emergency providers in reaching LEP communities. Without clear and proactive planning to strategically meet the needs of LEP communities, disaster scenarios will have adverse effects for LEP groups, deepening the health disparities that already exist for these populations.

LEP populations are at increased vulnerability because they are less likely to understand directives and warnings. Medical interpreters are potential key cultural and linguistic linkages to LEP communities. Reaching LEP groups through readiness training of medical interpreters is a strategy for effectively mobilizing a cultural and linguistic responder support force. Medical interpreter preparedness is a model for (1) public health disease reporting, public health information, and outbreak response for LEP populations; (2) culturally competent risk communication to LEP populations; and (3) a strategic, integrated systems approach for mobilizing linguistic support for public health and emergency responders.

BACKGROUND AND SIGNIFICANCE OF PROBLEM

Currently, numerous resources are dedicated to the topics of disaster preparedness and emergency response. A major educational, technical, and financial resource is the federal government. The topic of disaster preparedness is addressed by multiple federal agencies, including the Centers for Disease Control and Prevention (CDC), the Department of Homeland Security (DHS), and the Federal Emergency Management Agency (FEMA). The most available and widespread resources provided by these agencies are information and educational tools for public health professionals and the general public. These tools are disseminated on their websites and updated on a regular basis.

Much of the technical and financial resources of CDC and Health Resources and Services Administration (HRSA) under the Department of Health and Human Services (DHHS), and FEMA within the DHHS are dedicated to strengthening national public health

infrastructure. State and local public health agencies have been urged by federal agencies to develop bioterrorism and emergency response plans. Since the attacks of 9/11, more resources have been made available to state and local jurisdictions, and progress has been made in developing local preparedness plans.¹ Despite all the resources that have been dedicated to the preparedness arena, research has shown that there are still significant gaps in state and local infrastructure.²⁻⁵ These studies illustrate that additional resources are needed to provide local public health agencies with more frontline workers to mitigate and respond to threat agents.⁶

Of increasing concern in public health is the exclusion of LEP populations in public health preparedness planning, notably in critical areas such as disaster/emergency situations. According to the 2004 American Community Survey Data Profile Highlights, in King County, the most populous county in Washington State, 21.7% of those aged 5 years and older speak a language other than English at home, including (in order of prevalence spoken) Spanish, Chinese, Vietnamese, Tagalog, and Korean. This statistic compares nationally to 18.7% of those aged 5 years and older who speak a language other than English at home.⁷ Thus, the gap in adequately addressing disaster preparation, planning, and response for LEP populations is particularly critical given the U.S./Katrina experiences and current public attention regarding a pandemic flu outbreak.

To date, little information exists on the involvement of medical interpreters as stakeholders in health-care planning, the public health role of interpreters, and the perspectives and training needs of medical interpreters. The literature on medical interpretation and interpreters is primarily focused on the effects of medical interpretation, implementation of medical interpretation services, the quality of medical interpretation, and provider/clinician training on use of medical interpreters.⁸⁻¹³ These studies on the emerging field of medical interpretation, along with a growing focus on cultural competency in health care and laws requiring the provision of health-care interpretation, have stimulated a growing interest in research on interpretation services.¹⁴⁻¹⁶ There are several gaps in the literature that are of consequence for LEP populations in public health planning: (1) the possible roles of medical interpreters as culture brokers and gatekeepers for their language communities, (2) medical interpreters' perspectives of and experiences in their professional role as interpreters, and (3) the training, support, and resource needs of interpreters.¹⁷

Finally, medical interpreters are an untapped, strategic planning resource in disaster preparedness/

emergency response for LEP populations. Current planning drills and exercises have not integrated an approach to addressing the needs of LEP populations, such as tabletop exercises and hospital disaster drills. While translation of target public health disaster information into select languages has occurred, issues such as literacy variation within and between language groups and information access by LEP communities to written materials continue to present planning and systems response challenges.

SETTING

Harborview Medical Center (HMC) is a King County-owned comprehensive health-care facility and Level I adult and pediatric regional trauma center that serves Washington, Alaska, Idaho, and Montana. It serves a diverse patient population and provides more than one-third of all charity health care in Washington State.

The HMC Interpreter Services department enables the organization to provide equal access to care to LEP patients, one of HMC's priority populations. The Interpreter Services department employs 56 interpreters (31 permanent and 25 hourly) who provide interpretation in 32 languages and dialects. Additional language coverage is accessed through contracts with three agency language banks. In 2003, more than 100,000 hours of interpreting were provided during 93,000 encounters in 83 languages and dialects. The most requested languages were Spanish, Somali, and Vietnamese. Because of its linguistic capacity and with the support of the Manager of Interpreter Services, HMC was identified as the site to conduct a pilot assessment of medical interpreters' training background, their experiences in interpreting, and their needs regarding disaster preparedness, planning, and response.

METHODS

An assessment of HMC's medical interpreters was conducted to determine their training background and experiences as interpreters and, in particular, their training needs for disaster/emergency situations. A background survey was developed and administered to all HMC interpreter staff through their July 2004 staff meeting. Participation was completely voluntary and 38 interpreters completed the survey. Survey content areas included background demographics (Table), language background, interpretation training and experiences, experiences with disaster situations, and their training and support needs, particularly concerning disaster preparedness.

To further illuminate the background survey find-

Table. Harborview Medical Center interpreters surveyed, July–August 2004

	Number (n=38)	Percent
Gender		
Female	14	36.8
Male	21	55.3
No response	3	7.9
Age		
24–35	6	15.8
36–45	5	13.2
46–55	11	28.9
56–65	9	23.7
66+	3	7.9
No response	4	10.5
Ethnicity		
African ^a	8	21.0
Asian ^b	17	44.7
Caucasian ^c	5	13.2
Hispanic/Latino	5	13.2
No response	3	7.9

^aIncludes Ethiopian, Eritrean, Somali, Oromo, and Sudanese

^bIncludes Cambodian, Chinese, Filipino, Indian, Laotian, Malaysian, and Vietnamese

^cIncludes Jewish, Lebanese, and Russian

ings, interpreters who completed the survey were asked to participate in follow-up qualitative interviews. Again, participation was voluntary and 21 of the 38 interpreters who completed the background surveys agreed to be interviewed. Interviews ranged from 45 to 90 minutes in length. Interview content areas clustered around five categories: (1) cultural definitions and descriptions of disaster and emergency, (2) disaster preparedness training and support needs of interpreters, (3) medical interpreters' perceptions of their language communities' definitions and descriptions of disaster and emergency, (4) medical interpreters' perceptions of their language communities' preparedness for a disaster, and (5) strategies for disaster preparedness planning for their respective language communities.

Data from the background surveys were coded and entered into SPSS 12.0 for analysis.¹⁸ With permission from each participant, qualitative interviews were digitally recorded and professionally transcribed as soon as possible following each interview. Background surveys and qualitative interviews were anonymous, with no personal identifiers linking the data. Two members of the project team reviewed audio recordings to verify accuracy of transcriptions, after which the audio recordings were destroyed.

Transcripts were reviewed multiple times by three members of the project team. First, initial impressions of common themes across analytic categories based

on the interview guide were generated. Then, themes were organized along the vertical axis of a matrix with the study participants along the horizontal axis. This structure was used to organize data from each of the transcripts and to allow comparison both among individuals and against developing themes. The three project team members continuously reviewed this process until no new themes were identified and agreement concerning data was achieved.

FINDINGS

Background survey

Among the 38 respondents, 19 first/native languages were identified and 30 interpreted languages were identified (Figures 1 and 2). Twenty-six respondents interpreted in two or more languages, representing a wide range of linguistic capacity.

Training background reflected wide variation in terms of level and types of training; few listed any disaster-related trainings. A wide range of training needs was indicated ranging from disaster preparedness to interpretation, communication skills to medical topics, and terms to “anything.” Only five interpreters reported direct experience with interpreting in disaster situations.

Qualitative interviews

Medical interpreters repeatedly distinguished a disaster as an event that was unexpected and one that happened on a large scale. A disaster was described as involving mass casualties, injuries, and/or displacement of people and possibly occurring along a spectrum of severity. Disaster was further described as a chaotic event over which there is no control. Additionally, different meanings were associated with disaster, dependent on location (region) and context (e.g., war, earthquake, famine).

Clear distinctions between disasters and emergencies were made. Several interpreters provided the linguistic

Figure 2. Languages interpreted

N=30		
• Arabic	• Hindi	• Russian
• Amharic	• Ilocano	• Somali
• Cambodian	• Indonesian	• Spanish
• Cantonese	• Lao	• Swahili
• Chao Chou	• Malaysian	• Tagalog
• Chinese	• Mandarin	• Taiwanese
• Dinka	• Mien	• Tigrinya
• English	• Oromo	• Ukranian
• German	• Polish	• Urdu
• Hebrew	• Punjabi	• Vietnamese

and cultural meaning equivalents for both “disaster” and “emergency.” Numerous examples of both disasters and emergencies were given, providing a richly varied cultural context to both “disaster” and “emergency.” In general, emergencies were distinguished as events that were smaller in scale, usually involving one or a few individuals who required immediate medical attention. Examples most commonly cited were car accidents and heart attacks, with one interviewee stating, “An emergency needs to be tended to immediately.” Disasters were described as larger-scale events and explained as follows: “It can be an earthquake, it could be terror, or they say terrorism or something, or it could be . . . a chemical disaster.”

There was consistency between interpreters’ cultural definitions and descriptions of disaster and emergency and those of their language communities. However, most interpreters reported that their respective language communities did not discuss the potential for disasters or engage in community discussions concerning disaster preparedness. For example, disaster is a taboo topic in some language groups and for other groups, the cultural belief is that disasters cannot be foretold and are in the hands of God or fate.

Medical interpreters repeatedly responded that communities are not prepared and that for many language communities, preparedness is not a concept. Though this may not be different from mainstream America as a reality, the cultural contexts for not being prepared differ by language, migration history, circumstances, and belief systems, to name a few. Significantly, several interpreters reported that many members in their respective language communities who have survived wars and civil conflict believe that America is a safe place; therefore, there is no need to prepare.

“I think like a lot of it, this is our final destination. If something happen [sic] in the United States, there’s no way you can get out of here . . . when you left

Figure 1. Native/first languages identified^a

N=19		
• Amharic	• Ilocano	• Spanish
• Arabic	• Mandarin	• Swahili
• Cambodian	• Mien	• Tagalog
• Cantonese	• Oromo	• Tigrinya
• Chinese	• Punjabi	• Vietnamese
• Dinka	• Russian	
• English	• Somali	

^aSeven respondents listed two native languages.

[sic] home, that's it. This is your last place." (Medical interpreter)

Overall, medical interpreters felt that LEP communities are not prepared and that there is a need for information and education.

Medical interpreters suggested a range of educational and informational strategies to reach their respective language communities for preparedness planning. Their ideas for developing information that is both appropriate and accurate and the best pathways for disseminating this information to their respective language communities centered on the following cross-cutting themes:

- Target small, ethnic, language-specific community businesses, such as small grocery stores and markets.
- Work through community organizations that are well connected with various culture/language communities. Such organizations can disseminate accurate information efficiently.
- Talk with community organization leaders, church pastors, and other religious leaders, such as temple monks at the pagoda/temple.

Most interpreters have at least some type of training in medical interpretation, but the levels and types of training varied. Only a few of the interpreters reported having received disaster-related training. Among the interpreters interviewed, wide ranges of training needs were identified (e.g., disaster response, dealing with contaminated patients, and mental health training) and several stated that any type of training would be welcome. Interpreters wanted to know the hospitals' expectation of their role as interpreters in a disaster scenario. They wanted to know how they were to deal with contaminated patients and what protective measures were in place for them as interpreters.

Similarly, most medical interpreters felt a need for personal disaster preparedness training and education. Some went so far as to report that they did not feel included in hospital planning for disaster scenarios, not only in areas of their own personal safety but also in terms of how to respond to the needs of LEP patients who would present in a disaster scenario. Finally, one interpreter captured a collectively held sentiment: "I would like to know as much as possible about the disaster and how I can prepare for it, because if I know that, I can transfer the knowledge to my community. So, I need more education and more exercise and practice . . ."

NEXT STEPS

A project that replicated the pilot assessment described in three additional health-care settings (a local metropolitan health department, a local consumer-based health-care cooperative, and a local ethnic minority nonprofit community-based primary health-care organization) was completed in September 2006. This project, funded through the Group Health Community Foundation Grants Program, collected data on 50 medical interpreters. Findings are currently being analyzed.

These three different organizational sites utilize medical interpreters to provide interpretation services to their target patient populations. However, each site provides interpretation services in different ways within different organizational structures to meet the health-care needs of diverse LEP populations within King County. By drawing on this larger sample of 50 medical interpreters across these settings, a greater understanding of medical interpreters and their potential contributions to enhanced disaster preparedness and response will be gained, allowing for a greater understanding of how to strategically coordinate and mobilize a linguistic force across systems to support emergency and public health first responders.

Finally, through the replication of this pilot, the findings allow for a more robust characterization of interpreters' needs and the strategies required to inform and serve their respective language communities regarding disaster preparedness. Two disaster preparedness trainings for interpreters and bilingual/bicultural staff from key community-based organizations were developed and implemented by the end of 2006. Thus, this project identified a critical gap in preparedness planning to meet the needs of a diverse LEP public.

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